i am forwarding some info i copied and pasted from 2-3 e-mails i've received on the public health data standards consortium list-serv. this group is sponsored by nchs and is concerned with ensuring that public health and health services research data needs, including behavioral health data needs, are addressed under hipaa. this recent correspondence gives you some insights into hipaa issues this group is concerned about. --steve

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A Memo to the Public Health and Research Communities

Re: Latest DSMO request for deletion of data elements from the X12N transaction standards.

I wanted all interested parties to be aware of latest request to the Data Standards Management Organization (DSMO) intended to reduce provider reporting burden. This request may have implications for data used by the public health, Medicaid, and research communities.

Next, I wanted to promote a discussion between interested parties so that we can better understand the implications of this request to existing and emerging, non-inpatient data collection efforts.

Attached is testimony presented to the NCVHS Subcommittee on Standards and Security by David Moertel. Also attached is a matrix listing data elements for immediate deletion from the 837 Professional and Institutional transaction standards.

I am concerned about several aspects of this request:

1. Removal of data elements that I _think_ have value to Medicaid, certain payers, and surely public health and research now or in the near future. While many data elements may not have value, there are critical ata elements I believe must be retained if our discharge data systems are to have value in the future:

Institutional: ATTENDING PHYSICIAN.
Institutional: Special program code for govt-funded/Medicaid programs
Professional: newborn weight, insurance type code, pregnancy indicator, LMP, special program code are those we should be most concerned about losing.

2. The process. Am I mistaken or was the philosophy at X12N to not take away data until there was a mechanism for replacement (e.g. claims attachment). For public health, this may take the form eventually of a designated implementation guide, but until there is something to shift these data elements into, isn't this at odds with the process?

3. HIPAA implementation in general. I don't know but I would think many payers and vendors are already gearing up to meet the current x12N transaction standards---will this drastic revision delay this for some of the industry with a head start in implementation?

RECOMMENDATIONS TO PHDSC:

I recommend a PHDSC call to at least discuss the ramifications of this DSMO request to our discharge systems. Non-inpatient data collection efforts are in their infancy, so we don't yet know the utility of many of the professional codes that are commonly collected today.

This discussion should include the feasibility of identifying data element "champions" to develop the business case for some of these elements. For example, NAHDO might want to understand the implications of removing attending physician from the institutuional claims and, if appropriate, champion the cause for Attending physician. Most of the 44 states with discharge data systems collect this field and this field is the cornerstone of quality improvement activites, both provider and community wide.

Balancing the provider reporting burden with the public good of comparative health services data will always be a challenge.

If you made to this point--you are an interested party. I look forward

to the discussion!

For those that might want to individually comment on the DSMO change request, that website is:

http://www.hipaa-dsmo.org/

Subject: [PH-CONSORTIUM-L] Data Element Change Requests from Mayo Foundation et al to Design ated Standards Maintenance Organizations (DSMO)

Good Afternoon to All
Denise Love posted/responded to a document which included the recent HIPAA change requests coming from the Mayo Foundation (and other providers and provider associations: Health Alliance, Allina Health System, Medical Group Management Association, Cleveland Clinic Foundation, AMA, AHA, HCFA to name a few of the 19 named organizations). Dave Moertel of the Mayo Foundation testified before the National Committee on Vital and Health Statistics on Feb 1 and also entered these change requests into the DSMO (HIPAA) change request website. The document basically says that health care providers do not want to implement the Claims/Encounter Transaction (837) for the Institutional or Professional guide as is.
If public health and health services researchers take issue with these data element changes, strong "business cases" must be made against each relevant request (no anecdotes). This is similar to the issues we successfully championed last year with the three data elements: Race, ethnicity, and mother's medical record number.
Today the process is somewhat changed due to a HIPAA DSMO "fast track". This is in place so that published addenda to the Final Transaction and Code Set Rule are possible by October, 2001. The "fast track" is for the first year requirement only
So from a practical perspective, to change the outcome we must be part of the process, which is:
1. The "fast track" process impacts the X12 process. This process starts within the X12 837 (claims/encounters) workgroup. I have requested (like Medicaid has) the opportunity to discuss the issues during this (first and most critical) decision making process. This will include conference calls held by the workgroup in the next 2-3 weeks. It is at this juncture that we need to present our "business cases" to the workgroup (like Medicaid plans).
2. The second step of the X12 process includes the workgroup sending their recommendations by April 18 to the Washington Publishing Company (WPC) so that WPC can post and allow for comments. A second comment period starts May 1 (for 30 days). This is our second opportunity to comment.
3. The third X12 step takes place at the June Trimester meeting (in St. Louis) at their Information Forum. The X12 837 workgroup (and other transaction workgroups) present their change recommendations in the Forum including their rationale based on the industry input from the above processes. This is a third opportunity to comment. A final decision is planned for June so that final addenda can be to HHS in August.
My experience at X12 tells me that participation up front (#1) leads to more successful outcomes. Please share with your agencies the document previously sent by Denise and share any "business cases" on the listserv that support keeping the relevant data elements within the 837 Institutional and Professional guides. You may want to discuss with your Medicaid contacts and any other partners so that we don't duplicate only compliment each others' efforts.

Statement to the
National Committee on Vital and Health Statistics'
Subcommittee on Standards and Security

Panel 1 - Reporting of industry's early experiences with HIPAA implementation.

Presented by David Moertel
February 1, 2001

My name is Dave Moertel. I am the Manager of Electronic Commerce for the Mayo Foundation. It is my pleasure to appear today on behalf of the Mayo Foundation and a number of other health care provider organizations before the Subcommittee on Standards and Security of the National Committee on Vital and Health Statistics (NCVHS). I would like to thank you for the opportunity to testify. My statements will respond to the questions that have been proposed by this panel – "Reporting of industry's early experiences with HIPAA implementation".

1. **Have you or your organizational members performed a gap analysis to compare the data you already have available electronically with the data that are contained in the HIPAA transactions. If so, what gaps are there between the data elements you collect electronically and what is within the HIPAA X12 837 Claims/Encounter Transaction Implementation Guide?**

Mayo created a HIPAA compliance team that focused on reviewing the HIPAA implementation guides. The team is also creating a gap analysis comparing data available electronically with the data contained in the HIPAA transactions. They found a large number of new data requirements and have determined that the infrastructure changes required to be in compliance are extensive. Based on this analysis, we convened a meeting of provider organizations, provider associations, and representatives from HCFA to review this list of elements. In addition to the Mayo Foundation, the group includes representation from Park Nicollet Health Services, Health Alliance, Allina Health System, Medical Group Management Association, Carle Clinic, Superior Consultants, Cleveland Clinic Foundation, Ascension Health, Fairview, Ochsner Clinic, American Academy of Dermatology, University of Alabama Health Services Foundation, University of Kansas Medical Center, Cape Girardeau Surgical Clinic, American Medical Association, American Hospital Association, American Dental Association, the National Uniform Claim Committee, as well as the Health Care Financing Administration. The group evaluated the Mayo analysis and determined that the gaps identified were common issues for the provider industry. The tables of these issues are attached in appendices A (837 Professional Guide) and B (837 Institutional guide). After reviewing the issues we went through an issue prioritization process and found that 29 of the issues from the Professional Guide and 15 issues from the Institutional Guide were considered priority 1 or high priority issues.

All of these issues are attached to this testimony. Instead of discussing each of the more than 40 issues individually at this meeting, I would like the opportunity to work with someone from the Subcommittee at another time in order to explain all of the issues and recommendations in detail.

2. **Is this gap a barrier for you to implement the HIPAA 837 standard? If so, what are your plans to resolve the barrier?**

The high priority items on our list are issues that create barriers to the implementation of the HIPAA 837 Standard. Even the low priority issues when viewed as a whole create a barrier.

In our provider group discussions, a common question was whether or not the new required data elements reflect a universal business need for the healthcare industry or are the requirements expressed by a single payer or state agency. A major issue that arises from the universal transaction philosophy is that the burden then falls on the provider for reporting all the requirements in the claim transaction. A given provider is now obligated to provide required elements, on all claims, to all payers even though none of the provider's business partners may need the element. Those payers who don't need the element for processing the claim will need to maintain the data element so they can either pass it back on a remittance advice or pass it on to a secondary payer as part of the COB process.

Our provider group believes that if the elements in question are not currently necessary for the billing of services, the elements should not be required for HIPAA implementation. It appears that some of these data elements do not reflect a universal need for the healthcare industry or they are the requirements expressed by a single payer or state agency. The HIPAA 837 Implementation Guides were developed for the purpose of reporting claims services from providers to payers. If the inclusion of some of these elements was to fulfill other needs (e.g., state public health reporting) they should not be required data elements to be reported on claims transactions. In fact, our Provider Group supports the position that the 837 standard should be utilized as the transaction to report data for public health purposes, however, we believe that a separate implementation guide should be developed to fulfill those needs.

The group believes that in order for administrative simplification and the health data standards addressed by the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) to be successful, some of the data elements in question are going to require some compromise. Often times there are other more widely accepted methods for capturing the same information. While the law provides the framework for administrative simplification, significant work still lies ahead for all those involved in these transactions, the modification of the standards and the implementation guides, the review processes needed to establish uniformity in the use of standard transactions, and overseeing and updating the process as needed.

As you may know, electronic data interchange (EDI) involves the exchange of information not only between parties (trading partners) and their computers, but also between business applications. When communication is exchanged electronically, each party reformats its outbound message from its internal processing format into a standardized data format. This process is referred to as data translation and is performed for both inbound and outbound data. For example, the trading partner that receives a standardized-formatted electronic message translates the incoming message into their own internal format before processing the message in its application system. By using a standardized message, including uniform data content, organizations can communicate effectively with each other.

As the implementation date of these standards moves closer, the implementation guides that have been developed for the transactions must be adopted consistently across the industry. Our group believes it is unreasonable to expect that every provider in the nation will be required to modify their system and collect and report certain data in order to accommodate a single or small number of payers. We found that in many of the cases, it may be impossible to collect the required data element information.

Furthermore, our analysis found that in some cases providers would have to make modifications to their systems to comply with the requirements of the new standards. In other cases, we believe an industry review must be done to identify the percentage of the industry that requires certain data elements. If that percentage is low (based on the number of payers and/or volume of claims), then the requirement should be removed.

In addition, we found that there are other data elements that are required due to certain state law requirements (e.g. Indiana Medicaid). This means that every provider in the county is required to report a certain element even if only one state or payer requires the data. This defies the purpose of HIPAA, which is to create a universal national standard. These types of requirements need to be eliminated. With the establishment of the DSMO process, we believe that future requests to fulfill the requirements of an individual payer or provider will not be accepted.

Our plan is to send all of our issues through the DSMO process for review. Our concern is that the DSMO process is set up to handle issues with new versions of the guides. We are seeking immediate relief from the Secretary this year. The cost of compliance with the current data requirements will impose substantial financial risk to the healthcare industry. If the DSMO process is utilized, healthcare participants will be required to make costly infrastructure changes to be in compliance with data requirements indicated by the current implementation guides. As is indicated in the law, the secretary may adopt a modification any time within the first year if the secretary determines the modification is necessary to permit compliance with the standard.

3. **What other implementation issues do you have with any of the other HIPAA standard transactions, and what are your plans to resolve these issues?**

Many of the organizations that we are working with are following the proposed implementation schedule that has been outlined by the WEDI – SNIP process, therefore, our focus has been on the claims transaction. However, we intend to analyze all of the other implementation guides, and certain code sets, in the order in which they were identified in the WEDI-SNIP implementation schedule. For example, the remittance transaction may not pose as large of a risk to the provider community because the onus seems to be on the payer when it comes to transmitting the data content. However, the group has discussed some problems with the claims adjustment reason codes and CAS reject codes.

The claim adjustment and service adjustment segments provide the reasons, amounts and quantities of any adjustments that the payer made either to the original submitted charge or to the units related to the claim or service(s). The standardized list of claim adjustment group codes (OA, CO, CR, PI and PR) are to provide explanations of the liability of the financial adjustment to the claim or service line. As a provider, use of OA (Other Adjustment) makes it difficult to ascertain the liability of the provider or patient. Use of PI (Payer Initiated Reductions) can also be difficult for providers as it implies to our patients that the provider should be taking a reduction to the payment, even though the provider is not legally obligated to do so under a contract or government regulation. Although the implementation guide does recommend that payers should avoid the OA group, it does not prohibit payers from using that group code.

The CAS reject codes, 16 (Claim/service lacks information which is needed for adjudication.) and 125 (Claim/service adjusted due to a submission/billing error(s).) are the most oblique for providers and will automatically require a follow up phone call if the proprietary information is not also transmitted by the payer and thereby understood by the provider.

The group has also discussed the provider taxonomy codes and we believe that there will be problems for providers if required to report them to payers. Providers and probably payers will face costly infrastructure changes if they use the provider taxonomy codes because the list is extremely granular and out of date. Payers are asking providers to report information (e.g., provider specialty) that should already be in a payers system. This is an adjudication problem with the payers systems. There are other ways to identify specialty instead of putting the burden on the providers. For example, a physician could be Board

certified in several specialties or subspecialties. This is certainly true for the Mayo environment. It becomes a big problem for the billing department because they are responsible for submitting the claims. They may not know which specialty to submit for the services. Provider specialty is not currently reported and should not be a required HIPAA data element for providers to report in the future.

The group determined that the NDC codes will present major problems for both professional and institutional claims reporting. Not only is the 11 digit length of the NDC an issue, but the mapping of the J codes to the NDC codes would be a manual process in the clinic setting. Training, of course, would be necessary for clinic personnel to identify the NDC code for each drug supplied to each patient and this responsibility may go beyond the scope of the personnel's licensure or training. In addition, how would drug "mixes" or "cocktails" be handled? Would separate NDC codes be required for each drug or would only one drug be identified. When mixes or cocktails are used, would the clinic or hospital then be considered a manufacturer? Would they need their own manufacturing code? There are a number of questions that have come up and I have attached some of our questions as appendix C. The provider group has concluded that the NDC codes should not be used for professional and institutional HIPAA claims reporting purposes.

4. **Are there other implementation issues i.e., the X12 formatting or structure; HIPAA education; industry and government communication? If so, what are they and what are your plans to resolve them?**

The provider community faces a significant education issue. The issues that we have outlined are known to the members of our HIPAA Provider workgroup, but what about the thousands of providers and their vendors who don't know about the gaps that we've identified and the extensive infrastructure and practice changes that will be required? For many of the providers, who do become aware of the issues, they may not have the financial resources to make the required system changes necessary for compliance. We view the X12 formatting and structure as simple mapping issues. The bigger issue is having the data available. The gaps that we have identified will require significant changes throughout the providers system. This will have to begin with the physician, nurse or paramedical staff who is charting the information and would need to be carried all the way through to the patient accounting system.

On behalf of the Mayo Foundation and the other participants in our group, I would like to emphasize our shared commitment to advancing standardization and administrative simplification. However, there are several issues that we believe need to be addressed. The following points summarize my statement and recommendations for achieving the goals intended by administrative simplification:

- The group evaluated the Mayo analysis and determined that the gaps identified were common issues for the provider industry. A common question that was discussed was whether or not the new data elements that are required reflect a universal business need for the healthcare industry or are the requirements expressed by a single payer. The group believes that most of elements that we are concerned about do not reflect a universal business need.
- The HIPAA 837 Implementation Guides were developed for the purpose of reporting claims services from providers to payers. If the inclusion of some of these elements was to fulfill other needs (e.g., state public health reporting) they should not be required data elements. In fact, our provider group supports the position that the 837 standard should be utilized as the transaction to report data for public health purposes, however, we believe that a separate implementation guide should be developed to fulfill those needs.

- In some cases providers would have to make modifications to their systems to comply with the requirements of the new standards. In other cases, we believe an industry review should be done to identify the percentage of the industry that requires certain data elements. If that percentage is low (based on the number of payers and/or volume of claims), then the requirement should be removed.
- There are some data elements that are required due to certain state law requirements (e.g. Indiana Medicaid). This means that every provider in the country is required to report a certain element even if only one state or payer requires the data. These types of requirements need to be eliminated. This goes against everything that HIPAA is trying to create (i.e. a universal national standard).
- We are seeking immediate relief from the Secretary this year. The cost of compliance with the current data requirements will impose substantial financial risk to the healthcare industry.
- Providers and probably payers will face costly infrastructure changes if they use the Provider Taxonomy codes because the list is extremely granular and out of date. Payers are asking providers to report information (e.g., provider specialty) that should already be in a payers system. Provider specialty is not currently reported and should not be a required HIPAA data element for providers to report in the future.
- It was determined that the NDC codes will present major problems for both professional and institutional claims reporting. The provider group has concluded that the NDC codes should not be used for professional and institutional HIPAA claims reporting purposes.
- Our plan is to send all of our issues through the DSMO process for review. Our concern is that the DSMO process is set up to handle issues with new versions of the guides. We are seeking immediate relief from the Secretary this year. As is indicated in the law, the secretary may adopt a modification any time within the first year if the secretary determines the modification is necessary to permit compliance with the standard.
- All of these issues are attached to this testimony. Instead of discussing each of the 40 issues individually at this meeting, I would like the opportunity to work with someone from the Subcommittee at another time in order to explain all of the issues and recommendations in detail.

Thank you for this opportunity to present the views of this provider group. I would be pleased to respond to any questions that you might have.

837 Professional Claims Guide

o	Category or Loop	Segment Name or Short Description	Loop #X12 ID Element Page Number	Comments – Condition Statements	Action Steps Recommendation	12/05/00 – 1/24/01 Conference Call Comments	Priority 1) High 2) Medium 3) Low
1	Service Line Information	**Product/Service ID Qualifier**	2400 SV1 SV101-1 Pg 401	Code identifying the type of description number used in product/service ID. (e.g. HC-HCPCS codes, N1 NDC in 4-4-2 format, N2= NDC in 5-3-2 format, etc.)	If 4010 837 is mapped prior to implementation of the NDC code requirement, payer maps will need to be changed at the time of NDC implementation	Priority-communicate to NCVHS that providers are very concerned and cannot report NDC Codes (Not required). Ask NCVHS to eliminate as a requirement for use by providers except for home infusion providers or retail pharmacy. NDC codes should not be required for professional or institutional claims.	1
2	Claim – Line Provider Information	**Referring Provider Rendering Provider Specialty Information**	PRV 2310A, 2310B Pgs 285 & 293 2420A, 2420F Pgs 504 & 544	Taxonomy Code usage requirement.	Refer to www.wpc.edi.com/ taxonomy /Codes.html	Communicate to NCVHS that this should not be required.	1
3	Patient Information	**Individual Relationship Code**	2000C PAT PAT01 Pg 154-155	Expanded list of relationship codes (25 codes) (e.g. life partner, handicapped dependent, ward, employee, adopted child, etc.)		This should not be a requirement. It is unlikely that a provider would know this. The payers would have this info in their eligibility file anyway and providers should not need to maintain. Also a potential privacy issue.	1
4	Patient Information HL	**Unit or Basis for Measurement Code**	2000B PAT PAT07-08	PAT07 - Required on claims for delivery services. Element used when the		This is data that is not currently gathered for billing services and will require a significant investment by providers to	1

o	Category or Loop	Segment Name or Short Description	Loop #X12 ID Element Page Number	Comments – Condition Statements	Action Steps Recommendation	12/05/00 – 1/24/01 Conference Call Comments	Priority 1) High 2) Medium 3) Low
		Weight - Newborn	Pg 115 & 2000C PAT PAT07-08 Pg 156	patient's age is less than 29 days old. PAT08 – newborn birth weight (item 2 related to EPO has been eliminated in this section)		report. This should not be required.	
5	Subscriber Information	**Insurance Type Code**	2000B SBR SBR05 Pg111-112	Required when the destination payer is Medicare and Medicare is not the primary payer. Indicates nine Medicare Secondary type codes.		Communicate to NCVHS that this should not be required because the provider will not be able to collect for billing services. Medicare has not required this information before, so why now?	1
6	Patient Information HL	**Pregnancy Indicator** (Determined by Payer)	2000B PAT PAT09 Pg 116 & 2000C PAT PAT09 Pg 156	Required when required by state law (e.g. Indiana Medicaid)		This is data that is not currently gathered for billing services. This should not be required. It is a situational field and HIPAA should supercede state law. The providers would not know all the state laws.	1
7	Claim Information	**Related Causes Information Related Causes Code & State Code**	2300 CLM CLM11 (1-5) Pg 175-177	Code identifying an accompanying cause of an illness, injury or accident. Expanded code options. Must identify state code where auto accident occurred.		What do the payers really want to know here? Providers may not know the "cause". Where does the provider's responsibility end and the payer's begin on these issues. "Abuse" and "Another party responsible" are not currently contained on the paper form. State codes are seldom collected or provided by providers. Is this truly the provider's responsibility to provide or should this be between the patient and payer. Medicare requires accident and employment issues currently.	1

o	Category or Loop	Segment Name or Short Description	Loop #X12 ID Element Page Number	Comments – Condition Statements	Action Steps Recommendation	12/05/00 – 1/24/01 Conference Call Comments	Priority 1) High 2) Medium 3) Low
8	Claim Information	**Special Program Code**	2300 CLM CLM12 Pg 178	Required if the services were rendered under the following circumstances/programs/projects: 01 = EPSDT or CHAP 02 = Physically Handicapped Children's Program 03 = Special Federal Funding 05 = Disability 07 = Induced Abortion – Danger to Life 08 = Induced Abortion – Rape or Incest 09 = Second Opinion or Surgery	Mostly applies to Medicaid – Government Funded Programs, however, SSO may also apply to commercial insurance payers	EPSDT is on the paper form but the other examples would be difficult for provider to determine. Some of the codes may violate the privacy rule. These are condition codes on the institutional claim and are not captured for professional claims. These should not be required and should be eliminated.	1
9		**Date-Order Date**	2300/2400 Pg180/Pg444	Required when claim includes an order (i.e. an order for services of supplies is being billed/reported)		This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected.	1
10		**Date – Referral Date**	2300/2400 Pg184/Pg439	Required when claim includes a referral		This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected.	1
11		**Date – Date Last Seen**	23/00/2400 Pg186/Pg445	➢ Required when claims involve service for an independent physical therapist, occupational therapist, or physician services involving foot care. ➢ This is the date that the patient was seen by the attending/supervising	Information currently collected for Medicare only.	Medicare only. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected.	1

o	Category or Loop	Segment Name or Short Description	Loop #X12 ID Element Page Number	Comments – Condition Statements	Action Steps Recommendation	12/05/00 – 1/24/01 Conference Call Comments	Priority 1) High 2) Medium 3) Low
				physician for the qualifying medical condition related to the services performed.			
12		**Date – Onset of Current Illness/Symptom**	2300/2400 Pg188/Pg 452	Required when information is available and if different than the date of service. If not used, claim/service date is assumed to be the date of onset of illness/symptoms		This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected.	1
13		**Date-Similar Illness/Symptom Onset**	2300/2400 Pg192/Pg460	Required when claim involves services to a patient experiencing symptoms similar or identical to previously reported symptoms		This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected.	1
14		**Date – Last Menstrual Period**	2300 CLM Pg 196	Required when claim involves pregnancy		This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected.	1
15		**Date – Estimated Date of Birth**	2300 CLM Pg 199	Required when the patient is pregnant		Communicate to NCVHS that this should not be required. This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected. Doesn't relate to claim payment.	1
16		**Date – Disability Begin**	2300 CLM Pg 201	Required on claims involving disability where, in the opinion of the provider, the patient was or will be unable to perform the duties		Communicate to NCVHS that this should not required. This date is not currently collected for professional claims and reported to payers.	1

o	Category or Loop	Segment Name or Short Description	Loop #X12 ID Element Page Number	Comments – Condition Statements	Action Steps Recommendation	12/05/00 – 1/24/01 Conference Call Comments	Priority 1) High 2) Medium 3) Low
				normally associated with his/her work.		It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected.	
17		**Date – Disability End**	2300 CLM Pg 203	Required on claims involving disability where, in the opinion of the provider, the patient, after having been absent from work for reasons related to the disability, was or will be able to perform the duties normally associated with his work		Communicate to NCVHS that this should not be required. This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected.	1
18		**Date – Assumed and Relinquished Care Dates**	2300 CLM Pg 212	Required on Medicare claims to indicated "assumed care date" and "relinquished care date" for situation where providers share post-operative care (global surgery claims). Assumed care date is the date care was assumed by another provider during post-operative care. Relinquished care date is the date the provider filing this claim ceased post-operative care. (See Medicare guidelines for further information)	54 Modifier indicates assumed care – no date required at this time. 55 Modifier indicates relinquished care-date sent currently	Communicate to NCVHS that this should not be required. This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected. Currently only required for a 55 modifier. No location for data on the print image. Commonly requires manual intervention.	1
19	Claim Information Amounts	**Patient Amount Paid**	2300 AMT AMT01-AMT02 Pg 220	Required if the patient has paid any amount towards the claim (claim level payment indication)		This is inconsistent with what is currently being collected on paper claim form. This is an arrangement between the patient and the provider. If a provider does not have an agreement with a particular payer this would not be reported. Should not be required.	1

o	Category or Loop	Segment Name or Short Description	Loop #X12 ID Element Page Number	Comments – Condition Statements	Action Steps Recommendation	12/05/00 – 1/24/01 Conference Call Comments	Priority 1) High 2) Medium 3) Low
20	Service Line Information	**Emergency Indicator**	2400 SV1 SV109 Pg 406	Emergency Indicator – Required	How to define emergency?	This will be a problem for providers. No clear industry definitions. Communicate to NCVHS that this should not be required.	1
21	Service Line Information	**Prescription Number**	2400 SV4 SV401 Pg 408	➢ Required if dispensing of the drug has been done with an assigned Rx number ➢ In cases where a compound drug is being billed, the components of the compound will all have the same prescription number. Payers receiving the claim can relate all the components by matching the prescription number.		Review payer industry to see who is using this information for a healthcare claim and if not this should be removed. Is it a proven universal need. Not required by Medicare.	1
22	Service Line Information	**Referral Date**	2400 DTP Pg 439	Required when service line includes a referral		This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected.	1
23	Service Line Information	**Test Date**	2400 DTP Pg 447	Required on initial EPO claims service lines where test results are being billed		This should be collected for dialysis only. This is an Errata issue.	1
24	Service Line Information	**Anesthesia Modifying Units**	2400 QTY QTY01 Pg 462-463	Required on anesthesia service lines if one or more of the extenuating circumstances coded in QTY01 was present at the time of service.	There are CPT4 codes and qualifying modifiers that should reflect this information. However, this is an implementation guide requirement. (Errata?)	Communicate to NCVHS that these are included in CPT or in HCPCS and that it should not be a requirement to report in QTY01 as "extenuating circumstances".	1
25	Service Line Information	**Test Results**	2400 MEA MEA01-MEA03	Required on service lines which bill/.report the following: Concentration, Hemoglobin,	Discussion at ANSI meeting indicates this	Discussion at ANSI meeting indicates this segment was intended for dialysis patients treated with EPO. Guide does not	1

o	Category or Loop	Segment Name or Short Description	Loop #X12 ID Element Page Number	Comments – Condition Statements	Action Steps Recommendation	12/05/00 – 1/24/01 Conference Call Comments	Priority 1) High 2) Medium 3) Low
			MEA03 Pg 464-465	Hematocrit, Epoetin, Starting Dosage, Creatin, and Oxygen	indicates this segment was intended for dialysis patients treated with EPO. Guide does not currently reflect this info. (Errata??)	treated with EPO. Guide does not currently reflect this info. (Errata??)	
26	Service Line Information	**Immunization Batch Number**	2400 REF Pg 478	Use when required by state law for health data reporting.		Is this encounter data or claims data? This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected.	1
27	Service Line Information	**Universal Product Number (UPN)**	2400 REF Pg 482	X12N has been informed by HCFA that this information will be required on Medicare claims in the near future. It may also be required by some state Medicaids. This segment has been added to the 4010 guide to allow providers to meet these requirements when they are implemented		This is not required by HIPAA at this time and has not been implemented. Therefore, it should not be a requirement to report and should be removed from the guide.	1
28	Dental Service	Procedure Modifier	Loop 2400 SV301-3 to SV301-6 Page 267	These are marked as situational data elements, which is misleading. There are no modifiers to any dental procedure code.	Usage for these data elements should be changed to NOT USED.	Usage for these data elements should be changed to NOT USED.	1
29	Line Adjudication Information	Procedure Modifier	Loop 2430 SVD03-3 to SV03-6 Page 303	These are marked as situational data elements, which is misleading. There are no modifiers to any dental procedure code.	Usage for these data elements should be changed to NOT USED when Product	Usage for these data elements should be changed to NOT USED when Product Service Qualifier (SVD03-1) is AD (American Dental Association Codes).	1

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					Service Qualifier (SVD03-1) is AD (American Dental Association Codes).		
30		**Date – Last Xray**	2300/2400 Pg197/Pg 454	Required when claim involves spinal manipulation if an xray was taken.		Communicate to NCVHS that this should not be required. This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected. This requirement was eliminated for Medicare Claims.	2
31	Claim Information	**Spinal Manipulation Service Information**	2300 / 2400 CR2 Pg 251-6/415-20	Required on all claims involving spinal manipulation. e.g. Counts – Measures – Subluxation level codes – Condition code		Medicare no longer requires this information. Communicate to NCVHS that this should not be required. This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected.	2
32	Patient Information HL (subscriber is patient)	**Date Time Period Format Date Time Period (Deceased Patient)**	2000B PAT PAT05-06 Pg 115 & 2000C PAT PAT05-06	Required if patient is known to be deceased. Date of death		Review payer industry to see who is using this information for a healthcare claim and if not this should be removed.	

o	Category or Loop	Segment Name or Short Description	Loop #X12 ID Element Page Number	Comments – Condition Statements	Action Steps Recommendation	12/05/00 – 1/24/01 Conference Call Comments	Priority 1) High 2) Medium 3) Low
			Pg 155-156				
33	Property & Casualty Claim Number	**Property & Casualty Claim Number**	2010BA REF REF01-REF02 Pg128-129 2010CA REF REF01-REF02 Pg 168 - 169	This is a property and casualty payer-assigned claim number. Required on property and casualty claims		Review payer industry to see who is using this information for a healthcare claim and if not this should be removed.	
34	Claim Information	**Claim Frequency Type Code**	2300 CLM CLM05-3 Pg 173-174	1 = Original Claim 6 = Corrected Claim 7 = Replacement Claim 8 = Void (Cancel Prior Claim)	Need to have clear definition on usage of number 6 and 7 from payers.	Follow recommendation of eratta group.	
35		**Date – Initial Treatment Spinal Manipulation**	2300/2400 Pg182/Pg458	Date required of initial spinal manipulation treatment. (Usually used in chiropractic setting, however, need to look at orthopedics and/or PMR)	"	This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected. **Required by Medicare**	
36		**Date-Acute Manifestation**	2300/2400 Pg190/Pg456	Required when Loop 2300 CR208 = A or M (the patient is in critical condition), the claim involves spinal manipulation and the payer is Medicare.		This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected.	
37		**Date – Accident**	2300 CLM Pg 194	Required if the claim stems from an accident		This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected.	
38		**Date – Hearing**	2300 CLM	Required on claims where a		Communicate to NCVHS that this should	

o	Category or Loop	Segment Name or Short Description	Loop #X12 ID Element Page Number	Comments – Condition Statements	Action Steps Recommendation	12/05/00 – 1/24/01 Conference Call Comments	Priority 1) High 2) Medium 3) Low
		and Vision Prescription Date	Pg 200	prescription has been written for hearing devices or vision frames and lenses and it is being billed on this claim		not required. This date is not currently collected for professional claims and reported to payers. It should not be required until the industry is surveyed and it is determined that it is essential and that it can be collected.	
39	Claim Level Numbers	**Service Authorization Exception Code**	2300 REF REF01-REF02 Pg 222-223	Required when providers are required by state law (e.g. New York Medicaid) to obtain authorization for specific services but, for reason listed in REF02, performed service without obtaining service authorization. (Check with your state Medicaid to see if this applies in your state)		Review payer industry to see who is using this information for a healthcare claim and if not this should be removed. Is it a proven universal need.	
40	Claim Information	**File Information**	2300 K3 Pg244-245 2400 K3 Pg 487	This has been included in the implementation guide to be used as an emergency kludge (fix-it) in the case of an unexpected data requirement by a state regulatory authority.		Review payer industry to see who is using this information for a healthcare claim and if not this should be removed. Is it a proven universal need.	
41	Service Line Information	**EPSDT and Family Planning Indicator**	2400 SV1 SV111-SV112 Pg 406	Situational: ➢ Family Planning is Required if applicable for Medicaid Claims ➢ Required if Medicaid services are the result of a screening referral		Review payer industry to see who is using this information for a healthcare claim and if not this should be removed. Is it a proven universal need.	

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	Category or Loop	Segment Name or Short Description	Loop # X12 ID Element Page Number	Comments – Condition Statements	Action Steps Recommendation	1/10/01 conference call	Priority 1) high 2) medium 3) low
1	Patient Information HL	**Unit or Basis for Measurement Code Weight - Newborn**	PAT07-08 S=Pg 107 P=Pg 104 *Prof Pg* *S=Pg 115* *P=Pg 155-156*	PAT07 - Required on claims for delivery services. Element used when the patient's age is less than 29 days old.	Requirements listed differently than in Professional Guide.	This is already captured using ICD-9 codes and has been rejected by NUBC several times. This would be very burdensome for providers to collect. This should not be required and should be identified as not used in both prof. and instit. Guides.	1 for both
2	Patient Information HL	**Pregnancy Indicator** (Determined by Payer)	PAT09 S=Pg 107 P=Pg 144 *Prof Pg* *S=Pg 116* *P=Pg 156*	Required when required by state law (e.g. Indiana Medicaid)	Monitor whether this is a requirement of Medicaid or any commercial payers.	This is a situational element and not currently gathered by providers. HIPAA should supercede state law and this should not be a requirement.	1 for both
3	Property & Casualty Claim Number	**Property & Casualty Claim Number**	REF01-REF02 S=Pg 119-120 P=Pg 155-156 *Prof Pg* *S=Pg 128-129* *P=Pg 168 - 169*	This is a property and casualty payer-assigned claim number. Required on property and casualty claims		There are codes on the UB92 that identify what the liability situation is (e.g., workers comp, etc). This is a situational element that would be very problematic for providers to report because the provider may not know if the claim is going to be used for property and	1 for both

	Category or Loop	Segment Name or Short Description	Loop # X12 ID Element Page Number	Comments – Condition Statements	Action Steps Recommendation	1/10/01 conference call	Priority 1) high 2) medium 3) low
						casualty purposes. This element should not be required and should be identified as not used in both professional and Institutional guides.	
4	Patient Information	**Individual Relationship Code**	PAT01 P=142-143 *Prof Pg P=Pg 154-155*	Expanded list of relationship codes (25 codes) (e.g. life partner, handicapped dependent, ward, employee, adopted child, etc.)		This should not be a requirement. It is unlikely that a provider would know this. The payers would have this info in their eligibility file anyway and providers should not need to maintain. Also a potential privacy issue. Codes that do not have a NUBC compliment should be eliminated.	1
5	Claim Information	**Related Causes Information** **Related Causes Code &** **State Code**	CLM11 (1-5) C=Pg161-163 *Prof Pg C=Pg 175-177*	Code identifying an accompanying cause of an illness, injury or accident. Expanded code options. Must identify state code where auto accident occurred.		This is collected elsewhere in the institutional guide. Institutional guide currently collects this with the external cause of injury codes or with occurrence codes. Therefore, this is a situational code and should not be required for institutional guide. Take out CLM11 on the Institutional Claim.	1 for institutional
6	Claim Information	**Special Program Code**	CLM12 C=Pg 163	Required if the services were rendered under the following	Mostly applies to Medicaid – Government Funded	This is collected elsewhere in the institutional guide. This should not be required	1 for institutional

	Category or Loop	Segment Name or Short Description	Loop # X12 ID Element Page Number	Comments – Condition Statements	Action Steps Recommendation	1/10/01 conference call	Priority 1) high 2) medium 3) low
			Prof Pg C=Pg 178	circumstances/programs/projects: 01 = EPSDT or CHAP 02 = Physically Handicapped Children's Program 03 = Special Federal Funding 05 = Disability 07 = Induced Abortion – Danger to Life 08 = Induced Abortion – Rape or Incest 09 = Second Opinion or Surgery	Programs, however, SSO may also apply to commercial insurance payers	in the institutional guide and should be labeled not used.	
7	Claim Information	**Yes/No Condition or Response Code**	CLM 18 C=Pg 163	Required/a Y value indicates that a paper EOB is requested; a N value indicates that no paper EOB is requested. **What does this mean - required field?**		This is used to ask the payer for a paper EOB. Therefore, a provider must report either a "y" or "n" for every claim. This is actually a COB issue. NUBC will discuss this issue at their next meeting.	1
8	Claim Information Amounts	**Patient Amount Paid**	AMT01-AMT02 C= Pg 182 *Prof Pg C= Pg 220*	Required if the patient has paid any amount towards the claim (claim level payment indication)		This might be used for contractual relationships but should not be required to report. This is a situational element but it is "required" if the patient makes a payment. The problem is with the note. If a provider does not have an agreement with a particular payer this would not be reported. Should not	1

	Category or Loop	Segment Name or Short Description	Loop # X12 ID Element Page Number	Comments – Condition Statements	Action Steps Recommendation	1/10/01 conference call	Priority 1) high 2) medium 3) low
						be required. This issue will be evaluated.	
9	Claim Level Numbers	**Service Authorization Exception Code**	REF01-REF02 C=Pg 195 *Prof Pg C=Pg 222-223*	Required when providers are required by state law (e.g. New York Medicaid) to obtain authorization for specific services but, for reason listed in REF02, performed service without obtaining service authorization. (Check with your state Medicaid to see if this applies in your state)		Review payer industry to see who is using this information for a healthcare claim and if not this should be removed. Is it a proven universal need.	1
10	Claim Information	**File Information**	2300 K3 C=Pg 204 *Prof Pg C=Pg 244-245 L=Pg 487*	This has been included in the implementation guide to be used as an emergency kludge (fix-it) in the case of an unexpected data requirement by a state regulatory authority.		Review payer industry to see who is using this information for a healthcare claim and if not this should be removed. Is it a proven universal need.	1
11	Claim – Line Provider Information	**Attending Physician** **Operating Physician** **Other Physician** **Referring Physician** **Specialty Information**	PRV03 pg 325 PRV03 pg 332 PRV03 pg 339 PRV03 pg 346 *Prof: Rendering & Referring Prov Pgs 285 & 293 Pgs 504 & 544*	Taxonomy Code usage requirement. Referring physician not captured currently. No place on paper UB to provide data. Attending, Operating, Other and Referring Physician can also be reported on a service line level. See pages 462-489.	Refer to www.wpc.edi.com/taxonomy /Codes.html	Refer to www.wpc.edi.com/taxonomy /Codes.html. Providers and probably payers will face costly infrastructure changes if they use the Provider Taxonomy codes because the list is extremely granular and out of date. Payers are asking providers to report information that should already be in a payers system. This is an adjudication problem with	1

	Category or Loop	Segment Name or Short Description	Loop # X12 ID Element Page Number	Comments – Condition Statements	Action Steps Recommendation	1/10/01 conference call	Priority 1) high 2) medium 3) low
						the payers systems. There are other ways to identify specialty. This is not currently reported and should not be a required element.	
12	Service Line Information	**Product/Service ID Qualifier**	SV202-1 Pg 446-447 *Prof Pg: 401*	Code identifying the type of description number used in product/service ID. (e.g. HC-HCPCS codes, N1 NDC in 4-4-2 format, N2= NDC in 5-3-2 format, etc.)	If 4010 837 is mapped prior to implementation of the NDC code requirement, payer maps will need to be changed at the time of NDC implementation	A DSMO request regarding this issue has already been submitted.	1
13	Service Line Information	**Prescription Number**	SV4 Pg 450-451 *Prof Pg: 408*	➢ Required if dispense of the drug has been done with an assigned Rx number ➢ In cases where a compound drug is being billed, the components of the compound will all have the same prescription number. Payers receiving the claim can relate all the components by matching the prescription number.		Review payer industry to see who is using this information for a healthcare claim and if not this should be removed. Is it a proven universal need. Not currently required by any known payers.	1
14	Service Line Information	**Date Time Period Format Qualifier**	DTP 02-03 Pg 457	➢ In cases where a drug is being billed on a service line, the Date of Service DTP may be used to indicate the range of dates through which the drug will be used by the patient. Use RD8 for this purpose. ➢ In cases where a drug is being billed on a service		Providers and probably payers are concerned about this. Its use needs to be clarified in the guide. It probably should be eliminated.	1

	Category or Loop	Segment Name or Short Description	Loop # X12 ID Element Page Number	Comments – Condition Statements	Action Steps Recommendation	1/10/01 conference call	Priority 1) high 2) medium 3) low
				line, the Date of Service DTP is used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written).			
15	Service Line Information	**Assessment Date**	DTP Pg 458-459	➢ Required when an assessment date is necessary (i.e. Medicare PPS processing.) ➢ Refer to Code Source 132 National Uniform Billing Committee (NUBC) Codes for instructions on the use of this date.		The use of this element should be clarified in the guide. It probably should be eliminated.	1
16	Minimum/ Maximum Field Size			➢ Use UB Field length.			

NDC Codes

NDC Codes	
Replace HCPCS J Codes for identifying drugs	
Code is 11 digits: first 5 indicate manufacturer, next 4 is the product, next two indicates the dosage/package size	
ISSUE	**COMMENTS**
1. NDC codes are used to purchase product	a. Code for drug is assigned by bid. Doesn't change if substitution is made
	b. Default manufacturer is built into the system
2. Matching NDC code to patient medical record documentation	a. NCD codes are assigned by bid. (hosp)
	b. Orders are stable, but product can vary by hour/day. Substitutions may be made throughout stay, e.g. 800 mg may be given as one pill, or two 400 mg pills
	c. Billing is dependent on charting in clinic setting.
	d. brand vs generic use
	e. If substitution is made by vendor, cost remains as contracted. However, if the substituted medication is higher priced, and the NDC code has a higher charge assigned, will one patient be billed more than another dependent upon the NDC code?
	f. Charting doesn't usually state the manufacturer
3. Charge Data Master (CDM) conversion is necessary to accommodate # of digits	a. CDM # is unique to drug, dose and dosage form

NDC Codes	
Replace HCPCS J Codes for identifying drugs	
Code is 11 digits: first 5 indicate manufacturer, next 4 is the product, next two indicates the dosage/package size	
ISSUE	**COMMENTS**
4. Interface between Billing Office and CDM	a. Pricing of drugs on the clinic side is not consistent
	b. Mapping of J codes to NDC codes would be a manual process in a clinic
	c. Training would be necessary for clinic personnel to identify NDC code for each drug supplied to each patient
	d. Excessive CDM file
	e. New data base in Orders
Interface between Billing Office & CDM (continued)	f. Billing System would have to pass NDC # to Patient Accounting System (would both J code and NDC code have to be passed?)
	g. Update of billing records - how to identify all possible codes?
5. "Mixes" or "Cocktails"	a. Would separate NDC codes be required for each drug or would only the major drug be identified?
	b. Is the clinic or hospital considered a manufacturer? Would they need their own mfg code?
6. "lowest denominator" requirement for APCs	a. Inconsistency between APC requirements (lowest denominator & units) and HIPAA requirements (NDC code describes dose)
7. Manufacturer buyout - code changes	a. How to keep track of mergers, does the NDC code change if we have product from one company, who then changes names?
8. Electronic Medical Record System	a. How does this affect upcoming Electronic Medical Record Systems? How would the drug be identified?
	b. Would a new data table need to be built?

NDC Codes	
Replace HCPCS J Codes for identifying drugs	
Code is 11 digits: first 5 indicate manufacturer, next 4 is the product, next two indicates the dosage/package size	
ISSUE	**COMMENTS**
9. Paper Claims	a. Are there upcoming revisions to HCFA 1500? HCFA cannot accommodate # of digits
	b. Need for dual coding system?
	c. How can we determine whether the claim is going out paper or electronic at the time of charge capture? Which code system would we use? Would we need crosswalk? Would both have to be passed from the Billing System to the Patient Accounting System
	d. Scanners for major payers cannot read 11 digits
	e. Delay in DRO if manual identification and crosswalking needed
	f. Who will be required to crosswalk? Provider or payer?
paper claims (continued)	g. If electronic claim is rejected for some reason , and must go paper, a conversion table would have to be built , as well as having add'l screens and data fields added.
	h. Would paper be preferred over electronic? Especially by smaller institutions?
10. Implementation time	a. How would implementation be determined for multiple payers?
	b. Would we have any testing time?